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1. Inpatient hospital services other than those provided in an institution for mental diseases.

_X__ Provided: ____ No limitations __X__ With limitations*

2.a. Outpatient hospital services.

_X__ Provided: ____ No limitations __X__ With limitations*

b. Rural health clinic services and other ambulatory services furnished.

_X__ Provided: __X_No limitations ___ With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

__X_ Provided: __X_No limitations ___ With limitations*

3. Other laboratory and x-ray services.

_X__ Provided: ___ No limitations __X_With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

__X__ Provided: ____ No limitations __X__With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of child-bearing age.

__X__ Provided: __X__ No limitations ____ With limitations*

*Description provided on attachment.

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5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

__X__ Provided: ____ No limitations __X__With limitations*

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

__X__ Provided: ____No limitations __X__With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

__X__ Provided: ____ No limitations __X__With limitations*

Not Provided: ____

b. Optometrists' services.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

c. Chiropractor's services.

____ Provided: ____No limitations ____With limitations*

Not Provided: __X__

d. Other practitioners' services. Identified on attached sheet with description of limitations, if any.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

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7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

__X__ Provided: ____No limitations __X__With limitations*

b. Home health aide services provided by a home health agency.

__X__ Provided: ____No limitations __X__With limitations*

c. Medical supplies, equipment, and appliance suitable for use in the home.

__X__ Provided: ____ No limitations __X__ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

__X__ Provided: ____ No limitations __X__ With limitations*

e. Other Medical services, supplies, equipment and appliances.

__X__ Provided: ____ No Limitations __X__ With limitations*

8. Private duty nursing services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

9. Clinic services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

*Description provided on attachment.

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10. Dental services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

11. Physical therapy and related services.

a. Physical therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Occupational therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

__X__ Provided: ____ No Limitations __X__ With limitations*

Not Provided: ____

12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Dentures.

__X__ Provided: ____ No limitations __X__ With limitations*

*Description provided on attachment.

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12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist. (continued)

c. Prosthetic devices.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

d. Eyeglasses.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: _X___

b. Screening services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Preventive services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

d. Rehabilitative services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

*Description provided on attachment.

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14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Nursing facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

c. Intermediate care facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

15.a. Intermediate care facility services for individuals with developmental disabilities who are determined in accordance with section 1902(a)(31) of the Act, to be in need of such care.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

16. Inpatient psychiatric facility services for individuals under 21 years of age.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

*Description provided on attachment.

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17. Nurse -midwife services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

18. Hospice care (in accordance with section 1903(o) of the Act.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

19. Case management services and Tuberculosis related services.

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided: ____ With limitations*

Not Provided: ____

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

____ Provided: ____ With limitations*

Not Provided: __X__

20. Special sickle-cell anemia-related services in accordance with section 1905(a) and section 1903(a)(3)(E) of the Act.

____ Provided: ____ With limitations*

Not Provided__X__

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20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__X__ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

____ Provided ____ No limitations ____ With limitations*

Not Provided: __X__

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.

__X__ Provided: ____ No limitations __X__ With limitations

Not Provided: ____

23. Certified pediatric or family nurse practitioners' services.

__X__ Provided: __X__ No limitations ____ With limitations*

*Description provided on attachment.

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24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

__X__ Provided: _____No limitations __X__ With limitations*

Not Provided: ____

b. Services provided in religious non-medical health care facilities.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Reserved.

_____Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

d. Nursing facility services for residents under 21 years of age.

__X__ Provided: ____ No limitations __X__With limitations*

Not Provided: ____

e. Emergency hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

*Description provided on attachment.

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25. Home and Community Care for Functionally Disabled elderly individuals, as defined, described and limited in Supplement 2 to attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A..

_____ Provided: __X__ Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

A. Authorized for the individual by a physician in accordance with a plan of treatment.
B. Provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and
C. Furnished in a home.

__X__ Provided

__X__ State-Approved (Not Physician's) Service Plan Allowed
__X__ Services Outside the Home also Allowed.
__X__ Limitations Described in Attachment 3.1-A, Page 10-1

27. An alien who is a non-qualified alien or a qualified alien subject to the five-year ban and is otherwise eligible for Medicaid is eligible only for care and services necessary to treat an emergency medical condition as defined in section 1903(v) of the Act.

28. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

*Description provided on attachment.

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Description of Service Limitations

1. Inpatient hospital services

a. Prior authorization is required for psychiatric inpatient care.

b. Chronic pain management is limited to inpatient services provided by a Department of Social and Health Services (department)-approved pain center in a hospital.

c. Long-term acute care services are provided in department-approved hospitals and require prior authorization. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care outside of a hospital's intensive care unit.

2. a. Outpatient hospital services

(1) Hospital-owned institutional facilities that are hospital-based may provide outpatient hospital services to eligible clients when authorized by the department to do so.

(2) Freestanding hospital-owned institutional facilities that are nonhospital-based may provide outpatient services to eligible clients when authorized by the department to do so.

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3. Other laboratory and x-ray services

a. Laboratory services

Pathology services are considered to be the same as laboratory services. The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

Drug screens only when medically necessary and when:

- Ordered by a physician as part of a medical evaluation; or
- As drug and alcohol screens required to assess suitability for medical tests or treatment. For opiate substitution and pregnant women clients in the department's contracted treatment programs, drug screens for monitoring alcohol/drug use are reimbursed through a contract issued by the department.

One each of the following, per client per day:

- Blood draw fee; and
- Catheterization for collection of urine specimen.

b. Radiology services

The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

The following services require prior approval through the Expedited Prior Authorization (EPA) process:

- Outpatient magnetic resonance imaging (MRI);
- Positron Emission Tomography (PET) scans;
- More than one annual screening mammogram for clients forty (40) years of age and older (based on the National Cancer Institute (NCI) recommendations regarding screening mammograms); and
- General anesthesia for radiological procedures. Allowed only when the medically necessary procedures cannot be performed unless the client is anesthetized.

Portable x-ray services furnished in the client's home or a nursing facility are limited to films that do not involve the use of contrast media.

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4. a. Nursing facility services.

Prior approval of admission.

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4. b. Early and periodic screening, diagnosis, and treatment

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a program providing EPSDT to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. In conformance with 1905(r) of the Act, all medically necessary diagnosis and treatment services are provided regardless of whether the service is included in the plan. Limitations do not apply other than based on medical necessity.

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5. a. Physicians' services

Exceptions for noncovered services and service limitations are allowed when medically necessary and prior authorized by the department.

(1) Critical care.
- A maximum of three hours of critical care per client per day.
- More than one physician may be reimbursed if the services provided involve multiple organ systems (unrelated diagnosis).
- In the emergency room, only one physician is reimbursed.

(2) Newborn care and neonatal intensive care unit (NICU) services.
- One routine NICU visit per client per day.
- Prolonged care and newborn resuscitation when the physician is present at the delivery (in addition to the one routine visit).

(3) Osteopathic manipulative therapy.
Up to ten osteopathic manipulations per client, per calendar year.

(4) Physical exams:
Routine physical exams are covered in specific instances, including but not limited to:
- EPSDT screening
- Nursing facility placement exams
- Disability determinations for Title XVI-related individuals
- Yearly exams for developmental disability determination (DDD) clients

(5) Physician care plan oversight.
Provided once per client, per month. A plan of care must be established by the home health agency, hospice, or nursing facility, and the physician must provide 30 minutes or more of oversight each calendar month to the client.

(6) Physician standby services.
Must be:
- Requested by another physician; and
- Involve prolonged physician attendance without direct (face-to-face) patient contact.

The service must exceed 30 minutes.

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5. a. Physicians' services (continued)

(7) Physician visits.

Limited to:

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility.
- One inpatient hospital visit per client, per day, for the same or related diagnosis.
- One office or other outpatient visit per non-institutionalized client, per day, for an individual physician, except for return visits to an emergency room.

Professional inpatient services during the follow-up period are paid only if they are performed on an emergency basis and are unrelated to the original surgery.

(8) Psychiatric services.

- Outpatient psychotherapy and electroconvulsive therapy, in any combination - one hour per day, per client, up to a total of twelve hours per calendar year. Includes family or group psychotherapy.

- Psychiatric diagnostic interview examinations - one in a calendar year unless a new mental health diagnosis occurs.

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5. b. Medical and surgical services furnished by a dentist

Short stay procedures also take place in ambulatory surgery settings.

(1) Non-emergent oral surgeries performed in an inpatient hospital setting are not covered. The exceptions to this are DDD clients and children 18 years of age and under, whose surgery cannot be performed in an office setting (e.g., orthognathic cleft palate bone grafting). Prior written authorization is required. Documentation must be maintained in the client's record.

(2) Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with, craniofacial anomalies or cleft lip or palate or severe handicapping malocclusion:

(a) Clients in the EPSDT program through age twenty (20);

(b) Clients in the children's health program through age eighteen (18);

(c) Clients in the CN program through age twenty (20).

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law

a. Podiatrists' services

(1) Foot care is covered only for specific medical conditions that must be treated by an M.D., D.O., or podiatrist.

(2) The treatment of flat feet, or non-medically necessary treatment of fungal disease is not covered.

b. Optometrists' services

(1) Frames, lenses, and contact lenses must be ordered from the department's contractor.

(2) The department covers medically necessary eye examinations, refractions, eyeglasses (frames and glasses), and fitting fees as follows:
- Every 24 months for asymptomatic adults 21 years or older; and
- Every 12 months for asymptomatic children 20 years or younger, and clients identified by MAA as developmentally disabled.

(3) The department covers medically necessary contact lenses, as defined in rule. Normal replacement for contact lenses is every 12 months.

(4) Exceptions to numbers (2) and (3) above will be considered for all individuals based on medical necessity.

6. d. Other practitioners' services

All other practitioners covered by the department include, but are not limited to, the following licensed practitioners: psychologists, respiratory therapists, certified pediatric/family nurse practitioners, advanced registered nurse practitioners, dental hygienists, denturists, chiropractors (for EPSDT only), dietitians, nutritionists, occupational therapists, pharmacists, physical therapists, podiatrists, radiological technicians, speech/language pathologists, audiologists, licensed non-nurse midwives, birthing centers, and registered nurses first assistants. These practitioners are limited to services within their scope of practice.

Counselors, social workers, and other practitioners are covered as specified in other sections of the State Plan and as approved by the department.

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6. d. Other practitioners' services (cont.)

(1) MAA does not cover services provided by:
- Acupuncturists
- Christian Science practitioners or theological healers
- Herbalists
- Homeopathists
- Naturopaths
- Masseuses
- Masseurs
- Sanipractors

(2) Licensed non-nurse midwives.
- To participate in home births and in birthing centers, midwives must be a MAA-approved provider.

(3) Psychologists.
- One psychological evaluation per client's lifetime is covered.
- Neuropsychological testing requires prior authorization.

(4) Registered nurse first assistants.
- Registered Nurse First Assistants (RNFA) must provide services under the direction of a performing surgeon.

(5) Dietitians.
Medical Nutrition Therapy is a face-to-face interaction between a licensed/certified dietitian and the client and/or client's guardian for the purpose of evaluating and making recommendations regarding the client's nutritional status.

The service must be medically necessary and the client must be 20 years of age or younger with an EPSDT referral.

(6) Freestanding Birthing centers.

Definition: A freestanding birthing center is a specialized facility licensed as a childbirth center by the State's Department of Health (DOH).

- The DOH licensed birthing centers that have a core provider agreement with the department are authorized to provide necessary facility services.
- Eligible clients must meet medical criteria.

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7. Home health care services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

(1) Applies to home health agency and to services provided by a registered nurse when no home health agency exists in the area.

(2) Approval required when period of service exceeds limits established by the department.

(3) Nursing care services are limited to:

(a) Services that are medically necessary;

(b) Services that can be safely provided in the home setting;

(c) Two visits per day (except for the services listed below);

.

(d) Three high risk obstetrical visits per pregnancy; and

(e) Infant home phototherapy that was not initiated in the hospital setting.

(4) Exceptions are made on a case-by-case basis.

b. Home health care services provided by a home health agency

Home health aide services must be:

(1) Intermittent or part time;

(2) Ordered by a physician on a plan of care established by the nurse or therapist;

(3) Provided by a Medicare-certified home health agency;

(4) Limited to one medically necessary visit per day; and

(5) Supervised by the nurse or therapist biweekly in the client's home.

(5) Exceptions are made on a case-by-case basis.

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7. Home health care services (cont.)

c. Medical supplies, equipment and appliances suitable for use in the home

Medical supplies, equipment and appliances must be:

(1) Medically necessary;

(2) Ordered by the treating physician; and

(3) In the plan of care.

All of the following apply to durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related services suitable for use in the home:

(4) Purchase of equipment and appliances and rental of durable medical equipment require prior approval.

(5) Must be billed separately under a DME provider number.

(6) Are subject to the requirements in Washington Administrative Code.

(7) Specific reusable and disposable medical supplies, prosthetics, orthotics, and non-durable equipment that have set limitations, require prior approval (PA) to exceed those limitations.

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Therapies are limited to:

(1) Clients who are not able to access their care in the community; and

(2) To medically necessary care.

When physical therapy and occupational therapy are both medically necessary during the same certification period in order to meet the client's physical or occupational therapy needs, the physician must document on the plan of care that the services are distinctly different and not duplicated.

Exceptions are made on a case-by-case basis.

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7. Home health care services (cont.)

e. Other Medical services, supplies, equipment and appliances

(1) The Oxygen and Respiratory Therapy Services Program provides oxygen and/or respiratory therapy equipment, services, and supplies to eligible clients who reside at home or reside in nursing homes when medically necessary.

(2) Home infusion-parenteral nutrition equipment and supplies are provided when medically necessary.

- One germicide and/or one antiseptic allowed on the same day. Justification for exceeding this limit must be documented in the client's file.

(3) The Medical Nutrition Program provides medically necessary nutrition and related equipment and supplies, when the client is unable to meet daily nutritional requirements using traditional foods alone, due to injury or illness.

Limitations described below do not apply to the Medical Nutrition Program for EPSDT purposes. Exceptions to these limitations are allowed based on documented medical necessity.

- A licensed and certified dietitian must evaluate all clients 20 years of age and younger within 30 days of initiation of medical nutrition, and periodically (at the discretion of the licensed/certified dietitian) while the client is receiving medical nutrition.
- Initial assessments limited to 2 hours (or 8 units) per year.
- Reassessments limited to no more than 1 hour (or 4 units) per day.
- Group therapy limited to 1 hour (or 4 units) per day.

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8. Private duty nursing services

The purpose of the Private Duty Nursing (PDN) Program is to reduce the cost of healthcare services through equally effective, more conservative, and/or less costly treatment in a client's home. The department's Health and Recovery Services Administration has oversight for the program for clients 17 years of age or younger. Eligible clients must meet all of the following: be 17 years of age or younger; need continuous skilled nursing care that can be provided safely outside an institution; and have prior authorization from the department. PDN program services for those age 18 and older are administered by the department's Aging and Disability Services Administration, and are indistinguishable from services for those under age 18.

The department contracts with state licensed home health agencies to provide PDN services. These agencies are not required to obtain Medicare certification to provide PDN services. Within the home health agency, private duty nursing services must be performed by a licensed and appropriately trained registered nurse and/or a licensed practical nurse. For persons 18 years and older with an approved exception to policy, a private (non-home health agency) RN or LPN under the direction of the physician can provide PDN services only when the geographic location precludes a contracted home health agency from providing services, or when no contracted home health agency is willing to provide PDN services.

PDN services meet complex medical needs for persons who require at least four continuous hours of skilled nursing care on a day-to-day basis. Services provide alternatives to institutionalization in a hospital or nursing facility and are not intended to supplant or replace other means of providing the services.

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9. Clinic services

a. Freestanding kidney centers

(1) Description of facility: A center devoted specially to treating End Stage Renal Disease (ESRD)

(2) Description of service: Peritoneal dialysis or hemodialysis for ESRD.

(3) Program coverage: Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. includes physician services, medical supplies, equipment, drugs, and laboratory tests.

(4) Prior authorization: Required for the facility but not the physician. Initial authorization may be granted for up to three months. Reauthorization may be granted for up to twelve months.

(5) Reimbursement: This service is reimbursed according to attachment 4.19-B.

b. Freestanding ambulatory surgery centers

Allowed procedures are covered when they:

- Are medically necessary; and
- Are not for cosmetic treatment surgery.

Some procedures are covered only when they:

- Meet certain limitation requirements; and
- Have been prior authorized by the department.

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10. Dental services and dentures

a. Limited to selected medically necessary services for the identification and treatment of dental problems or the prevention of dental diseases. Some of these services may require prior authorization.

b. Crowns are covered only for children through age twenty (20) and require prior authorization.

c. Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with craniofacial anomalies or cleft lip or palate or severe handicapping malocclusion. Limits may be exceeded based on medical necessity.

(1) Clients in the EPSDT program through age twenty (20);

(2) Clients in the CN program through age twenty (20)

d. Clients of the Developmental Disability Division may receive additional services

e. Dentures

For limitations indicated in (1) below, limits may be exceeded based on medical necessity.

(1) For clients through age twenty (20), allowed per client:

- Complete, immediate, and overdenture dentures - one maxillary and one mandibular denture in a ten year period.
- Partial dentures - once every five years, subject to limitations.
- Replacement full or partial dentures - requires prior authorization when requested within one year of the seat date of the previous dentures.
- Rebase - once every five years and the dentures must be at least three years old
- Relines and adjustments - included in the reimbursement if done within six months of the seat date. After six months, allowed once every five years.

(2) For clients age twenty-one (21) and over, allowed per client:

- Immediate dentures - one maxillary and one mandibular denture in a lifetime, and requires prior authorization.
- Complete dentures - one maxillary and one mandibular denture in a ten-year period and requires prior authorization.
- Resin and cast metal framework partial dentures - once in a ten-year period and requires prior authorization.
- Replacement resin partial dentures – not allowed within the ten-year period.

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10. Dental services and dentures (continued)

- Replacement cast metal framework partial dentures - once in a ten-year period.
- Complete and partial denture relines - once in a five-year period.

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11. Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders

a. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).

b. Prior authorization required to exceed set limits for clients twenty-one (21) years of age and older as follows:

(1) Prior Authorization is required for physical therapy (PT) when the client is

- 21 years of age and older and requires services beyond one PT evaluation and 48 units PT per year, per client per diagnosis, or
- 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay, and requires services beyond one PT evaluation and 144 units of PT per year, per client, per diagnosis.

(2) Prior Authorization is required for occupational therapy (OT) when the client is:

- 21 years of age and older and requires services beyond one OT evaluation and 12 OT visits per year, per client; or
- 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay and requires services beyond one OT evaluation and 36 OT visits per year, per client.

(3) Prior Authorization is required for speech therapy (ST) when the client is:

- 21 years of age and older and requires services beyond one speech evaluation and 12 speech visits per year per client; or
- 21 years of age and older and has a qualifying diagnosis and requires services beyond one Speech evaluation and 36 speech visits per year per client.

c. Services for individuals with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist.

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12. a. Prescribed drugs

Drug Coverage

(1) Covered outpatient drugs as defined in Section 1927 (k)(2) of the Act are those which are prescribed for a medically accepted indication and produced by any manufacturer, which has entered into and complies with an agreement under Section 1927(a) of the Act.

(2) Prescriptions written as a result of an EPSDT visit will be approved as ordered by the prescriber when that information is communicated to the therapeutic consultative services (TCS) clinical pharmacists.

(3) Generic drugs, insulin and diabetic supplies, contraceptives, antipsychotics, anticonvulsants, antidepressants, chemotherapy, antiretrovirals, immunosuppresants and hypoglycemic rescue agents will be exempt from triggering a TCS review. During a TCS review, all covered outpatient drugs, as defined in Section 1927 (k) (2) of the Act will be authorized for the Medicaid client, if the prescriber deems them to be medically necessary.

(4) Under Washington Administrative Code, pharmacies are advised provide an emergency supply of medically necessary drugs when TCS reviews are pending.

(5) Drugs excluded from coverage as provided by Section 1927(d) (2) of the Act, include: DESI drugs, experimental drugs; weight loss drugs (unless prescribed for an indication other than obesity), drugs for cosmetic purposes, drugs for fertility and drugs for smoking cessation (except that Zyban is covered for pregnant or post-partum women according to Washington Administrative Code).

Prior Authorization

(6) Prescription drugs may be subject to prior authorization by the agency to ensure that drugs are prescribed and dispensed appropriately.

(7) MAA determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following:

- Safety
- Potential for abuse or misuse
- Narrow therapeutic index
- High cost when less expensive alternatives are available

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12. a. Prescribed drugs (continued)

(8) Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and provides for the dispensing of at least a 72-hours supply of medications in emergency situations.

Therapeutic Consultation Service (TCS)

(9) In the Therapeutic Consultation Service (TCS), all Medicaid recipients will have their entire drug profile reviewed by clinical pharmacists after the fifth request for a brand-name drug is processed in a calendar month or anytime a request for a non-preferred drug is processed. A non-preferred drug is a drug in a drug class that has essentially the same clinical safety and efficacy as the drug of choice, but is not the preferred drug. TCS is not a limit, but rather a service to provide a clinical pharmacy review of the client's entire drug therapy. This review is conducted to assure that Medicaid clients are receiving appropriate drug therapy, without therapeutic duplication or without potentially serious drug-drug interactions or drug-disease conflicts. Prescribers direct clients' drug therapy and have the final say. Reports will be available that indicate the numbers of prescriptions that were dispensed as originally ordered by the prescriber.

Supplemental Rebate Agreement

(10) The state is in compliance with Section 1927 of the Act. The state will cover drugs of manufacturers participating in the Medicaid Drug Rebate Program. Based on the requirements for Section 1927 of the Act, the state has the following policies for drug rebate agreements:

- Manufacturers are allowed to audit utilization rates.
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D).
- A rebate agreement between the state and a drug manufacturer for drugs provided to the Washington Medicaid population, submitted to CMS on January 14, 2002, entitled "State of Washington Supplemental Rebate Contract," has been authorized by CMS.
- A rebate agreement between the state and a drug manufacturer for drugs provided to the Washington Medicaid population, submitted to CMS on January 16, 2004, entitled "State of Washington Supplemental Rebate Contract," has been authorized by CMS.
- The state reports rebates from separate agreements to the Secretary for Health and Human Services. The state will remit the federal portion of any cash state supplemental rebates collected on the same percentage basis applied under the national rebate agreement.
- All drugs covered by the program, irrespective of a prior authorization agreement, will comply with provisions of the national drug rebate agreement.

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12. a. Prescribed drugs (continued)

Preferred Drug List

- Pursuant to 42 U.S.C. section 1396r-8, the State is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization, and provides for the dispensing of at least a 72-hour supply of medications in emergency situations, in accordance with provisions of section 1927(d)(5) of the Social Security Act. The prior authorization process is described in chapter 388-530 WAC.
- Prior authorization will be established for certain drug classes or particular drugs in accordance with Federal law. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with the provisions of the national drug rebate agreement.
- A preferred drug list does not prevent Medicaid beneficiaries from obtaining access to medically necessary drugs of manufacturers that participate in the national drug rebate program.
- The State will utilize the Drug Utilization Review board to assure, that in addition to pricing consideration, preferred drugs are clinically appropriate.

Mail Order Delivery Service for Prescription Drugs

(11) The state contracts for a mail-order delivery service for prescription drugs using a competitive bid process. This service is available to all fee-for-service Medicaid clients statewide. Clients have the option of having prescriptions filled at either a local retail outlet of their choice or by the mail-order contractor.

All policies and procedures that apply to retail pharmacies also apply to the mail-order contractor, except for the following:

(a) The mail-order contractor is reimbursed at a mutually agreed upon level that is less than reimbursement provided to local retail pharmacies; and

(b) If authorized by the prescriber, the mail-order contractor may dispense the following drugs in up to a ninety-day supply:

(i) Preferred drugs identified by the state;

(ii) Generic drugs; and

(iii) Drugs that do not require prior authorization or expedited prior authorization.

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12. a. Prescribed Drugs (continued)

Citation	Provision
1935(d)(1)	The Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	(a) The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

_X_ **The following excluded drugs are covered:**

_X_ (i) Agents when used for anorexia, weight loss, weight gain:
progestin derivative appetite stimulant, androgenic agents

_no_ (ii) Agents when used to promote fertility

_no_ (iii) Agents when used for cosmetic purposes or hair growth

_X_ (iv) Agents when used for the symptomatic relief cough and colds:
antitussives, expectorants, sympathomimetic agents, decongestants, antihistamine combination drugs, anticholinergic agents

_X_ (v) Prescription vitamins and mineral products, except prenatal vitamins and fluoride:
vitamin A, vitamin B12, folic acid, vitamin B1, vitamin B2, vitamin B6, vitamin D, vitamin E, vitamin C, vitamin B complex, selenium, zinc, vitamin K, sustained acting niacin, aminobenzoate potassium, hydroxocobalamin

_X_ (vi) Nonprescription (OTC) drugs:
analgesics/antipyretics, antacids, antidiarrheals, antibacterial topical preparations, antiemetic/antivertigo agents, antiflatulents, antifungals, antihistamines, antitussives, antiseptics, antiseborrheic agents, blood sugar diagnostics, decongestants, ear wax removers, electrolyte depleters, electrolyte replacements, emetics, expectorants, eye lubricants, eye vasoconstrictors, hemorrhoidal preparations, hyperglycemics,inhalation agents, irrigants,

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12. a. Prescribed Drugs (continued)

irritants/counter-irritants, keratolytics, laxatives/cathartics, lipotropics, nasal preparations, ointment/cream bases, oral sodium preparations, topical steroidal anti-inflammatories, topical antiparasitics, topical antivirals, topical anesthetics, urinary tract anesthetic/analgesics agents

no (vii) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

X (viii) Barbiturates:
Butalbital, Phenobarbital, Amobarbital, Pentobarbital, and Secobarbital.

X (ix) Benzodiazepines:

no (x) Agents when used to promote smoking cessation (for non-dual eligibles as Part D will cover):

____ **No excluded drugs are covered.**

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12. b. Dentures

These services have been moved under “Dental Services” based on CMS recommendation.

12. c. Prosthetic devices

(1) Prior approval required

(2) Hearing aids provided on the basis of minimal decibel loss

12. d. Eyeglasses (Included under “Optometrists’ Services”, section 6.b.)

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13. c. Preventive services

Disease State Management

The State of Washington will provide a statewide Disease Management Program to Medicaid clients eligible for Title XIX Medicaid coverage under the Categorically Needy Program (CNP), who receive services through the Medical Assistance Administration's (MAA's) fee-for-service system, and who have one or more of the following diseases:

- Asthma
- Congestive Heart Failure;
- Diabetes;
- End Stage Renal Disease (ESRD)or Chronic Kidney Disease (CKD);
- Chronic Obstructive Pulmonary Disease (COPD).

The State's Disease Management Program is designed to assist clients with chronic illness to achieve the following goals:

(1) Increase the client's (and/or their caregiver's) understanding of their disease so they are:

- More effective partners in the care of their disease;
- Better able to understand the appropriate use of resources needed to care for their disease(s);
- Able to identify when they are getting in trouble earlier and seek appropriate attention before they reach crisis levels; and
- More compliant with medical recommendations.

(2) Improve clients' quality of life by assisting them in "self-management" of their disease and in accessing regular preventive health care;

(3) Provide coordination among multiple case managers and health care providers;

(4) Improve adherence to national, evidence-based guidelines to improve clients' health status; and

(5) Reduce unnecessary emergency department visits and hospitalizations.

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13. c. Preventive services/Disease State Management (cont.)

Components of Disease State Management

Contracted disease management vendors will provide the following services to clients eligible for the program:

- Outreach that is sufficient to draw hard-to-serve clients into the program, including home visits or other face-to-face contact if the client does not have a telephone, or is unable to use the telephone.

- Twenty-four hour-a-day, seven days-a-week (24/7) toll free nurse telephone consultation and screening service staffed by licensed registered nurses. The toll free nurse service will provide advice and consultation to all clients in the enrollment group of 173,000 on a 24/7 basis. In addition, during each incoming call, the triage nurse will ask a series of questions designed to determine if the client has one of the conditions being served by the disease management program. If the caller has one of the conditions covered by this program, he or she will be transferred to either the McKesson Care Enhance program or the Renaissance ESRD program for further assessment and risk stratification.

- Once the client has been referred for further assessment, the appropriate contractor will provide more intensive screening to determine the client's risk level. The Contractor will then develop and implement an individual plan of care that addresses the client's multiple health, behavioral and social needs, and that ensures continuity, quality and effectiveness of care.

- Assistance to clients in accessing appropriate medical care, including assisting the client in finding a primary care provider (PCP) if the client does not already have a PCP.

- Assistance to clients in accessing necessary primary/preventive care and obtaining referrals for specialty services through appropriate channels, rather than obtaining care through the emergency department.

- Facilitation of appropriate collaboration between the client's family and/or caregivers, health care providers and community case managers in the development and implementation of the client's plan of care.

- Linkage between health care providers and allied health and social service agencies to facilitate access to services necessary for the implementation of the client's plan of care, including a system that allows providers to request specific care coordination services.

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13. c. Preventive services/Disease State Management (cont.)

Choice of Providers

The state assures that there will be no restrictions on a client's free choice of providers in violation of Section 1902(a)(23) of the Act. Eligible clients have free choice to receive or not receive disease case management services through contracted Prepaid Health Plans (PHPs) and may change nurse case managers within the PHP at any time. Eligible clients also have free choice of the providers of other medical care under the program.

Criteria for Disease Management Providers

(a) All Disease Management case managers shall be registered nurses who meet the requirements of the contracted disease management vendors.

All case management nurses shall be licensed in the State of Washington, Registered Respiratory Therapists licensed in the State of Washington may provide additional services.

(b) The State will contract with disease management companies who meet the program requirements.

(c) Entities who wish to contract with the Medical Assistance Administration to provide disease management services must meet the following conditions:

- Have an appropriate method for using MAA healthcare data to identify targeted disease populations;
- Have an evidence-based healthcare practice guideline for each targeted disease;
- Have collaborative healthcare practice models in place to include MAA's contracted physicians and support-service providers;
- Have patient self-care management education materials and methods appropriate to each targeted disease population;
- Have process and outcomes measurement, evaluation, and management systems;
- Have routine reporting processes that are proven to properly support disease management goals;
- Have demonstrable and successful experience in disease management for the targeted disease population;

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13. c. Preventive services/Disease State Management (cont.)

- Provide access to a 24 hour-a-day, seven days-per-week nurse call center;
- Have the ability to guarantee program savings; and
- Meet applicable federal and state laws and regulations governing the participation of providers in the Medicaid program.

Comparability of Services

All clients eligible to participate in the disease management program will receive comparable services, based on their level of disease and co-morbid conditions. All clients will receive be assessed for their risk level, and will receive follow up education and disease management services.

Inclusion Criteria

Target Group: The target group of Medicaid clients eligible to receive Disease Management services are clients who:

(1) Receive medical services through fee-for-service coverage;

(2) Are not institutionalized;

(3) Are high-risk clients with one or more diseases and conditions;

(4) Are not receiving specialized case management services through another program;

(5) Have a primary diagnosis of one of the diseases described in this document.

Enrollment/Disenrollment Process

This disease management program is a voluntary program. All clients in the enrollment group will have access to the toll-free Nurse Advice program. Additionally, those clients with any of the four disease states will be referred to the appropriate DM Vendor for further disease management. Any client may stop participating in the DM program at any time by calling the Disease Management vendor with whom the client is participating, or by calling the State's toll-free customer service line. This process is referred to as "opting out" of the Disease Management Program.

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13. c. Preventive services/Disease State Management (cont.)

Clients may also re-enroll ("opt in") in the Disease Management Program at any time by calling the appropriate disease management vendor, or the State's toll-free customer service line.

Payment methodology for the Programs

In accordance with federal interpretation, the disease management risk contracts. See attachment 4.19-B, IX, G for payment methodology.

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13. d. Rehabilitative services

(1) Physical medicine and rehabilitation as requested and approved.

(2) Alcohol detoxification is limited to three days in certified facilities which are:

(a) Within the physical location and the administrative control of a general hospital; or

(b) Freestanding facilities established to provide this service.

(3) Drug detoxification is limited to five days in certified facilities which are:

(a) Within the physical location and the administrative control of a general - hospital;

(b) Freestanding facilities established to provide this service.

(4) Adult day health is a supervised daytime program providing nursing and rehabilitative-therapy services. Adult day health services are only appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician.

(5) Chemical dependency treatment provided in certified programs that include:

(a) Outpatient treatment programs; and

(b) Treatment services, excluding board and room, provided in residential treatment facilities with 16 beds or less.

(6) Medical services furnished by a school district:

(a) Including evaluation, screening and assessment component for those students under consideration for an Individual Education Program or Individualized Family Service Plan; or

(b) Identified as part of a handicapped child s Individual Education Program or Individualized Family Service Plan.

Services to be provided will be physical therapy, speech therapy, occupational therapy, audiology, psychological services, counseling, and nurse services. Licensed/ classified personnel will provide services.

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13. d. Rehabilitative services (cont.)

7. Mental Health Rehabilitation services are integrated treatment services recommended by a mental health professional furnished by state licensed Community Mental Health Agencies. Services are provided to seriously mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. These services must be provided to reach the goals of an Individualized Service Plan. The payment rates are established per Attachment 4.19-B XVII.

The services to be provided are:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Services provided in Residential settings;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and,
- Therapeutic psychoeducation.

A. Definition of medical necessity as it relates to mental health services

Medical necessity or *medically necessary* – “A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation, or where appropriate, no treatment at all.

Additionally, the individual must be determined to 1) have a mental illness covered by Washington State for public mental health services; 2) the individual’s impairment(s) and corresponding need(s) must be the result of a mental illness;

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13. d. 7 Rehabilitative services/Mental health services (cont.)

3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support can not address the individual's unmet need.

Medical necessity is determined by a mental health professional. All state plan modality services are accessible based on clinical assessment, medical necessity and individual need. Individuals will develop with their mental health care provider an appropriate individual service plan. The services are provided by Community Mental Health Agencies licensed or certified by the Mental Health Division and provided by, or under the supervision of, a mental health professional. Services are assured in accordance with 1902(a)(23).

The following is a descriptive list of the employees or contracted staff of community mental health agencies providing care.

(1) *Mental health professiona***l** means:

(A) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;

(B) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(C) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.

Within the definition above are the following:

"Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

"Psychologist" means a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW;

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13. d. 7 Rehabilitative services/Mental health services (cont.)

"Social worker" means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

"Child psychiatrist" means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

"Psychiatric nurse" means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

"Counselor" means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

(2) *"Mental Health Care Provider"* means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

(3) *"Peer Counselor"* means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the Department of Health.

Peer Counselors must self identify as a consumer or survivor of mental health services. Peer Counselors must demonstrate:

1. That they are well grounded in their own recovery for at least one year;
2. Willingness to a pretest for reading comprehension and language composition; and,
3. Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Peer Counselors must be able to:

- Identify services and activities that promote recovery by instilling hope and experiences which lead to meaning and purpose, and which decrease stigma in the environments in which they serve;
- Articulate points in their own recovery stories that are relevant to the obstacles faced by consumers of mental health services;
- Promote personal responsibility for recovery as the individual consumer or mental health services defines recovery;
- Implement recovery practices in the broad arena of mental health services delivery system;
- Provide a wide range of tasks to assist consumers in regaining control over their own lives and recovery process (e.g., promoting socialization, self advocacy, developing natural supports stable living arrangements, education, supported employment);
- Serve as a consumer advocate;
- Provide consumer information and peer support in a range of settings; and,
- Model competency in recovery and ongoing coping skills.

The training provided/contracted by the mental health division shall be focused on the principles and concepts of recovery and how this differs from the medical model, the creation of self-help and coping skills and advocacy. Training will include:

- Understanding the public mental health system;
- What is peer support and how it promotes recovery;
- How to advocate for age appropriate peer support projects;
- How to facilitate groups and teams;
- Understanding self-directed recovery;
- How to create your own self-help coping skills plan;
- How to start and sustain self-help/mutual support groups;
- How to form and sustain a personal support team;
- How to promote recovery, self-determination and community reintegration;
- Assist consumers to do for themselves and each other;
- Assist in skill building, goal setting, problem solving;
- Assist consumers to build their own self-directed recovery tools; and,
- Assist consumers by supporting them in the development of an individual service plan that has recovery goals and specific steps to attain each goal.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Peer Counselors who were trained prior to the implementation of the Washington Administrative Code by National Consultants to be Certified facilitators who pass the test and the background check, and are registered counselors may be grandfathered as Peer counselors until January 2005. After January 2005, it will be necessary for them to take the training.

(4) *"Registered nurse"* means a person licensed to practice registered nursing under chapter 18.79 RCW.

(5) *"Nurse practitioner"* means a person licensed to practice advanced registered nursing under chapter 18.79 RCW.

(6) *"Licensed practical nurse"* means a person licensed to practice practical nursing under chapter 18.79 RCW.

(7). *"Mental health specialist"* means:

(1) A "*child mental health specialist*" is defined as a mental health professional with the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and
(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A "*geriatric mental health specialist*" is defined as a mental health professional who has the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and
(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An "*ethnic minority mental health specialist*" is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and
(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

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13. d. 7 Rehabilitative services/Mental health services (continued)

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) A "*disability mental health specialist*" is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.
(a) If the consumer is deaf, the specialist must be a mental health professional with:
(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and
(ii) Ability to communicate fluently in the preferred language system of the consumer.
(b) The specialist for consumers with developmental disabilities must be a mental health professional who:
(i) Has at least one year's experience working with people with developmental disabilities; or
(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

Staff Supervision means monitoring the administrative, clinical or clerical work performance of staff, students, interns, volunteers or contracted employees by persons with the authority to direct employment activities and require change. When supervision is clinical in nature, it shall occur regularly and may be provided without the consumer present or may include direct observation of the delivery of clinical care. Supervisory activities include the review of all aspects of clinical care including but not limited to review of assessment, diagnostic formulation, treatment planning, progress toward completion of care, identification of barriers to care, continuation of service and authorization of care.

B. DEFINITIONS

(1) *Brief Intervention Treatment:* Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

(2) *Crisis Services:* Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

(3) *Day Support:* An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

(4) *Family Treatment:* Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

(5) *"Freestanding Evaluation and Treatment"* Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

(6) *Group Treatment Services:* Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

(7) *High Intensity Treatment:* Intensive levels of service otherwise furnished under this state plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.
*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

(8) *Individual Treatment Services:* A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

(9) *Intake Evaluation:* An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

(10) *Medication Management:* The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

(11) *Medication Monitoring*: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

(12) *Mental Health Services provided in Residential Settings*: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment.

The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

(13) *Peer Support:* Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumers' ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Services provided by peer counselors to the consumer are noted in the consumer's Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

(14) *Psychological Assessment:* All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

(15) *Rehabilitation Case Management:* A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

(16) *Special Population Evaluation:* evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

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13. d. 7. Rehabilitative services/Mental health services (cont.)

(17) *Stabilization Services:* Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

(18) *Therapeutic Psychoeducation:* Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one’s disease, the symptoms, precautions related to decompensation, understanding of the “triggers” of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

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13. d. 8. Therapeutic child-care

Therapeutic child-care to treat psycho-social disorders in children under 21 years of age based on medical necessity. Services Include: developmental assessment using recognized, standardized instruments play therapy; behavior modification; individual counseling; self esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior. Prior approval is required. Payment rates are established per section X of Attachment 4.19-B.

Line staff, responsible or planning and providing these services in a developmentally appropriate manner must have an AA degree in Early Childhood Education or Child-Development or related studies, plus five years' of related experience, including identification, reporting, and prevention of child abuse and/or neglect.

Supervisory staff must have a BA in Social Work or related studies, plus experience working with parents and children at risk of child abuse and/or neglect. Experience can be substituted for education using a 2:1 ratio. Their responsibilities are for development, implementation and documentation of treatment plans for each child.

Agencies and individual providers must be approved as meeting Medicaid agency criteria and certification requirements under state law as appropriate.

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13. d. 9. Behavior Rehabilitation Services.

Behavior rehabilitative are services provided to children to remediate debilitating disorders, upon the certification of a physician or other licensed practitioner of the healing arts within the scope of their practice within state law. Prior approval is required.

Service Description

Specific services include milieu therapy, crisis counseling and regularly scheduled counseling and therapy, as well as medical treatment.

Milieu therapy refers to those activities performed with children to normalize their psycho-social development and promote the safety of the child and stabilize their environment. The child is monitored in structured activities which may be recreational, rehabilitative, academic, or a variety of productive work activities. As the child is monitored, intervention is provided to remediate the dysfunctional behaviors and encourage appropriate responses in a broad range of settings.

Crisis counseling is available on a 24 hour basis, providing immediate short term intervention to assist the child in responding to the crisis and/or stabilize the child's behavior until problems can be addressed in regularly scheduled counseling and therapy sessions.

Regularly scheduled counseling and therapy, as well as psychological testing, is provided. The purpose of which is to remediate specific dysfunctions which have been explicitly identified in a continually updated formal treatment plan. Therapy may be in an individual or group setting. It may be directed toward the child alone, the child within his/her biological or the adopted family, or the child within his/her peer group.

Medical treatment may also be provided. Twenty-four hour nursing is provided for children who are medically compromised to such an extent that they are temporarily unable to administer self care and are impaired medically/developmentally immediate the caretaker's ability to provide medical/remedial care.

Population to be Served

Children who receive these services suffer from developmental disabilities and behavioral/emotional disorders that prevent them from functioning normally in their homes, schools, and communities. They exhibit such symptoms as drug and alcohol abuse; anti-social behaviors that require an inordinate amount of intervention and structure; sexual behavior problems; victims of severe family conflict; behavioral disturbances often resulting from psychiatric disorders of the

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13. d. 9. Behavior Rehabilitation Services (cont.)

parents; medically compromised and developmentally disabled children who are not otherwise served by the state agency's Division of Developmental psychological Disabilities; and impairments.

Provider Qualifications

Service include Social Staff: Responsibilities development of service plans; individual, group, and family counseling; and assistance to child care staff in providing appropriate treatment for clients. The minimum qualification is a Masters Degree in social work or a closely allied field.

Child Care Staff: Responsibilities include assisting social service staff in providing individual, group, and family counseling; and therapeutic intervention to address behavioral and emotional problems as they arise.

Minimum qualifications require that no less than 50% of the childcare staff in a facility have a Bachelors Degree. Combinations of formal education and experience working with troubled children may be substituted for a Bachelor's degree.

Program Coordinator: Responsibilities include supervising staff, providing overall direction to the program and assuring that contractual requirements and intents are met.

Minimum qualifications are to be at least 21 years of age with a Bachelors Degree, preferably with major in study psychology, sociology, social work, social sciences, or a closely allied field, and two years experience in the supervision and management of the group care program for adolescents.

Counselor: Responsibilities include case planning, individual and group counseling, assistance to child care staff in providing appropriate treatment for clients, coordination with other agencies, and documentation of client progress.

Minimum qualifications are to be at least 21 years of age possessing a Master's Degree with major study in social one year work or a closely allied field and of experience in the care of troubled adolescents or, a Bachelor's Degree with major study in social work, psychology, and experience in the care of troubled adolescents.

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17. Nurse midwife services

Limited to facilities approved by the department to provide this services, or in the case of home births, to clients and residences approved for this service. To participate in home births, midwives must be a MAA-approved provider.

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18. Hospice care (in accordance with section 1903(o) of the Act.)

Also includes pediatric palliative care services that are provided for approved clients 20 years old and younger who have a life limiting diagnosis.

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20. Extended services for pregnant women, through the sixty days postpartum period. The extended services include:

a. Maternity support services, by a provider approved by the Department of Health and the department, consisting of:

(1) Nursing assessment and/or counseling visits;
(2) Psychosocial assessment and/or counseling visits;
(3) Nutrition assessment and/or counseling visit;
(4) Community health worker visit; and
(5) Child birth education.

b. Outpatient alcohol and drug treatment for pregnant and postpartum women consisting of a chemical dependency assessment by an Alcohol and Drug Abuse Treatment and Services Act assessment center, parenting education, and chemical dependency treatment.

c. Rehabilitation alcohol and drug treatment services, excluding room and board, for pregnant and postpartum women recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under State law. Services are provided in residential treatment facilities with 16 beds or less certified by the Division of Alcohol and Substance Abuse.

d. Genetic counseling performed by a provider approved by Parent-Child Health Services and the department.

e. Smoking cessation counseling, up to ten sessions, to include the following:

(1) Assessing the pregnant and postpartum woman's tobacco dependence;
(2) Providing advice and assistance, including a written smoking cessation plan; and
(3) If appropriate, prescribing smoking cessation pharmacotherapy, as needed.

Smoking cessation counseling may be provided by physicians, advanced registered nurse practitioners, licensed midwives, and physician assistants.

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22. Respiratory care services

As defined in rule, the department covers medically necessary oxygen and/or respiratory therapy equipment, supplies and services to eligible clients in nursing facilities, community residential settings, and in their homes. The above is prescribed by a health care practitioner authorized by law or rule in the State of Washington. Prior authorization is required for specified equipment, or when a request falls outside of the defined criteria.

Selected contracted nursing facilities are authorized to provide exceptional care needs to ventilator- and tracheostomy-dependent clients.

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24. a. Transportation

(1) Ambulance transportation is provided as an optional service for emergencies or as required by state law.

(2) All non-emergency transportation services, to assure clients have access to and from covered services, are provided using administrative matched dollars in accordance with Section 42 CFR 431.53, and are not considered a medical service described in the coverage section of the State Plan.

(3) Transportation for clients who also have Medicare Part D is provided at the same level of service as, and under the same restrictions for, prescription drug pickups.

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24. d. Nursing facility services for patients under 21 years of age

The admission requires prior approval.

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25. Home and community care for functionally disabled elderly Individuals, as defined, described and limited in Supplement 2 to attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A

Provided
__X__ Not provided

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26. Personal care services

a. Eligibility for services.

Persons must living in their own home, Adult Family Home, family foster home, children's group care facility or licensed boarding home.

b. Persons must be determined to be categorically needy and have three ADL needs requiring minimal assistance or one ADL need requiring more than minimal assistance. ADL assistance is defined in WAC 388-71-0202 and WAC 388-72A-0035 and WAC 388-72A-0040.

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27. An alien who is a non-qualified alien or a qualified alien subject to the five-year ban and is otherwise eligible for Medicaid is eligible only for care and services necessary to treat an emergency medical condition as defined in section 1903(v) of the Act.

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28. Program of all-inclusive care for the elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.